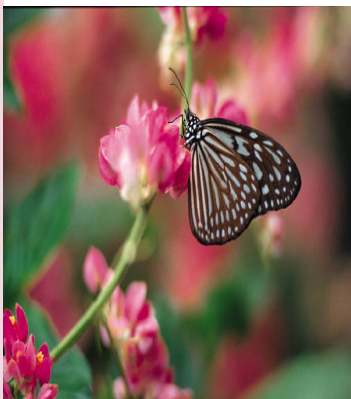




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BUREAU TALK

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www.dhss.mo.gov/HomeCare

STAFF CHANGES

January 2010 was a month filled with changes for the Bureau. We said goodbye to Wanda Roling, who retired Jan. 31 after 11 years of service with the Department of Health and Senior Services, including three years with the Bureau of Home Care and Rehabilitative Standards. We will miss Wanda's expertise and we appreciate all her contributions to the Bureau. Please join us in wishing her the best!

On another note, the Bureau has hired a new surveyor, Edna Nelsen. Edna comes to us from Republic, Mo. She brings with her many years of health care experience, including 16 years in hospice nursing. She previously worked as a long-term care surveyor with the Department of Health and Senior Services. Edna has already attended both the federal basic home health and hospice trainings. We are excited to have Edna as part of the surveying team. Please join the Bureau in welcoming Edna!

FAMILY CARE SAFETY REGISTRY FEE INCREASE

Effective April 1, 2010, the Family Care Safety Registry Worker Registration fee will increase to **\$10.00**. The fee increase results from a change in state law and is required by the Missouri State Highway Patrol.

The Family Care Safety Registry will return Worker Registration Forms submitted with the incorrect fees that are postmarked on or after 4/01/2010. Updated Worker Registration Forms will be available to download at www.dhss.mo.gov/FCSR on March 31, 2010, or may be obtained by calling the FCSR toll-free at 866-422-6872.

E-MAILS

To communicate effectively with the various agencies regulated by the Bureau of Home Care and Rehabilitative Standards, an email list-serve is used on a regular basis and includes the e-mail address of the **administrator** for all the agencies and facilities regulated by the Bureau.

This **administrator** contact information is **required by policy** since it is the means by which the Bureau notifies the agency of information such as the Survey Statements of Deficiencies, Annual Statistical Reports, Bureau Talks and other communications.

It is the responsibility of the agency to notify the Bureau immediately of any changes in e-mail contact information.

When the Bureau receives a notification of an e-mail change from your agency, you will receive an email from one of the following (depending on the facility type):

hospice-request@lphamo.org

home_health-request@lphamo.org

opt_corf-request@lphamo.org.

This message confirms that you wish to be added to the list serve, but you **MUST PROCEED WITH THE FOLLOWING STEPS:**

Click on the REPLY button

Type in PLEASE ADD

Click the SEND button- **this must be done to complete the process**

The system will then send an e-mail confirmation that will state: "Welcome to the Home Health and/or Hospice and/or OPT mailing list."

It is **imperative** that you forward all e-mail changes to Deb.Green@dhss.mo.gov or call the office at 573-751-6336.

CHANGES OF OWNERSHIP

Medicare Program Integrity Transmittal 318, Change Request 6750, was published December 18, 2009. This change request implements two provisions from the Home Health Agency (HHA) Prospective Payment System Final Rule (CMS-1560-F). One of the provisions, outlined in 42 CFR424.550 (b), holds that an HHA may not undergo a change of ownership if the effective date of the change occurs within 36 months after: (1) the effective date of the provider's enrollment in Medicare, or (2) the effective date of the last ownership change for the HHA. The effective date of the change was January 1, 2010.

EMSystem

At the time of a disaster, it is important for all providers to be aware of the resources that are available in their area or in the area of the disaster. The Missouri Hospital Association (MHA) has been working on the EM-System. By being a part of this system, an agency can keep informed of what's going on in the area hit by the disaster. They will be able to access the system and know such things as what hospitals are taking patients and which are on diversion; who has oxygen tanks available and who does not. The MHA hopes to have all providers signed on to the system by May 1, 2010.

CONTRACTED EMPLOYEES FOR HOSPICE

The Bureau wants to remind all hospices that the regulations do NOT allow for contracting of the core services. Per CFR 418.64, "A hospice must routinely provide substantially all core services directly by hospice employees.....These services include nursing services, medical social services and counseling."

CFR 418.64 also states, "A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances...." This would require prior approval by the Bureau and specific criteria would have to be met before this would be allowed. In the history of the Bureau, rarely has an agency met the required criteria. Please refer to the Interpretive Guidelines at L600 of the federal regulations. **Remember, you cannot use contract nurses for continuous care.**

THE HOSPICE INITIAL ASSESSMENT

It has been brought to the attention of the Bureau that there may be some hospices that are performing the Initial Assessment while the patient is still an inpatient. Per 418.54(a) Standard: Initial Assessment, "The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with 418.24 (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.) Per the Interpretive Guidelines, "The purpose of the initial assessment is to gather the critical information necessary to treat the patient/family's immediate care needs.

The assessment needs to take place in the location where hospice services are being delivered."

Unless the patient is currently being admitted to General Inpatient Care, the Initial Assessment cannot be done while the patient is in the hospital.

STATISTICAL REPORTS

The state hospice council recently met and revised the annual statistical report that is due every year by Jan. 31. Hospices will find that the 2010 statistical report will again be asking agencies to calculate their number of "unduplicated admissions". (The number of individuals admitted to the hospice for the calendar year, counted only once.) A patient who has revoked or been discharged would not be counted again.

OPERATION OF HOSPICE AGENCIES ACROSS STATE LINES

In the October 2009 Bureau Talk, hospice agencies were provided with the CMS S&C 09-58, dated September 18, 2009 (Attachment A). The subject of the S&C was Advance Copy – Hospice State Operations Manual (SOM) Sections 2080 – 2089. In section 2085, Operation of Hospice Across State Lines, the manual states, "When a hospice provides services across state lines, it **must** be certified by the State in which its CMS certification number (CCN) is based, and its personnel must be qualified in all States in which they provide services. The appropriate SA completes the certification activities. The involved states **must** have a written reciprocal agreement permitting the hospice to provide services in this manner...."

Missouri does not have reciprocal agreements with any of its bordering states. Therefore, due to the change in the SOM, agencies currently seeing patients in the bordering states will be required to obtain Medicare certification in those states.

CHANGES IN PROVIDER INFORMATION

The Bureau takes the opportunity to remind agencies that a CMS- 855A must be submitted to the fiscal intermediary for all provider changes. However, in the case of a request for a branch or a satellite location, an **approved** CMS-855A from the fiscal intermediary must be received in the Bureau prior to final approval of the newly requested location.

OPT FISCAL INTERMEDIARY CONTACTS

With any changes made to OPT provider information, a CMS- 855A must be submitted to your fiscal intermediary. WPS (Wisconsin Physician Services) is now the MAC (Medicare Administrative Contractor) for all OPT/SP providers. This form can be accessed and downloaded on CMS' website, www.cms.hhs.gov/MedicareProviderSupEnroll/. Once completed, the CMS-855A must be submitted directly to your contractor. WPS's mailing address for submitting the form is:

Overnight Mail Service:

WPS Medicare Part A
Medicare Provider Enrollment
3333 Farnam St. Suite 700
Omaha, NE 68131

Regular Mail Service:

WPS Medicare Part A
Medicare Provider Enrollment
P.O. Box 8310
Omaha, NE 68108-0310

The 855A application must be completed and returned to WPS for approval, with the final approval or denial made by the CMS Regional Office on all changes. Should you have any questions regarding this 855A application process or on other matters, please contact WPS Provider Enrollment area at 1-866-734-9444.

POSSIBLE DENIAL OF MEDICARE PAYMENTS

The Bureau has reminded agencies numerous times in the past that all location changes, whether parent, satellite, branch, or extension site, must have prior approval of the Bureau administrator. This request must be submitted in a timely manner to allow for your anticipated move date. Please allow 4-6 weeks for the processing of this request.

Please be aware that CMS has the final determination on the location change. If not approved, an unauthorized move could result in the denial of Medicare payments.

OASIS

It has now been more than three months since the implementation of OASIS-C! We hope the transition is going as smoothly as possible for your agency.

Policies and Procedures

It is evident from the conversations I have had with many agencies that everyone has been working hard on implementing the new data set and updating policies and procedures.

Many of you have voiced concern that if surveyed during this transition period, you may not have your policies and procedures completely updated addressing the new OASIS-C. The Bureau is aware that agencies need time to ensure that all policies and procedures are updated; therefore, a grace period of six months will be allowed. However, after that point, it would be expected that agencies will have in place and in effect all new policies and procedures.

Home Health Compare

Agencies have also been concerned about the process for updating Home Health Compare with the new OASIS C. The states recently received a memo from CMS Central Office outlining the process.

The memo states:

"While sufficient OASIS-C data is collected and risk models are developed, the CASPER and Home Health Compare (HHC) reports will remain static; the last available OASIS B-1 reports will remain in the system and on the HHC site until they are replaced with OASIS-C reports."

Sufficient numbers of patient episodes are needed in order to report measures based on new OASIS-C data. Measures based on patient sample sizes taken over short periods of time can be inaccurate and misleading because of seasonal variation and under-representation of long-stay home health patients. Once sufficient OASIS-C data have been collected and submitted to the national repository, CMS will begin producing new reports based on OASIS-C.

In March 2010, HHAs will be able to access OBQI/M report data through December 2009. OBQI/M reports will continue to be available after this date, but December 2009 will be the last month for which OBQI/M data is calculated for OASIS B1 data.

OASIS Cont.

Home Health Compare will be updated in April 2010 with OASIS B1 data for January 2009 through December 2009.

OASIS C Process, Outcome and Potentially Avoidable Measures will be transitioned between September 2010 and May 2011. Please see the attached grid for further dates. Specific details regarding these reports will be available closer to the implementation date of the Process Measures, scheduled for September 2010.

The attached grid referenced in this memo can be found in ATTACHMENT A.

What Agencies Need To Do To Stay Current

It is imperative that each agency keep current with CMS guidance on the OASIS-C.

In order to do that, you must have:

1. A current copy of the **OASIS-C guidance (Chapter 3)**. On Dec. 30, 2009, our office sent an e-mail via list-serve to all home health providers with information regarding the last minute change that CMS made to the OASIS –C Guidance. With a little less than one week before implementation, CMS released a revised version of the OASIS-C Guidance Manual (specifically the Chapter 3 Item Guidance). Please note that the latest version is still labeled Sept. 2009 on the front cover; you are not accessing the wrong file. To print off the latest version of the OASIS-C Guidance go to: <http://www.cms.hhs.gov/HomeHealthQualityInits/downloads/HHQIOASIS-CManual200912.zip>.
2. **CMS Quarterly Q & As**. There are now two sets of quarterly Q&As available that specifically address OASIS –C. They are October 2009 and January 2010. The next set of Q & As is due April 2010. To access these Q & As, go to www.oasiscertificate.org and click on *Resources*. As I stated numerous times in my trainings last fall, it is imperative that someone from your agency keep up with these quarterly Q & As and share them with other clinical staff.
3. The **General OASIS Q&As**. When CMS updated the OASIS data set, not only were new data items added, but many of the old data items were modified. Because of these modifications, some of the CMS Q&As were no longer accurate. Therefore, all the general CMS OASIS Q&As have been updated and can be obtained by going to www.qtso.com , and clicking on *OASIS*.

An agency that keeps its clinicians informed will be well ahead of the game!

OASIS Cont.

OASIS-C Q&As

Over the past several months, I have been compiling all the OASIS-C questions that I have received from providers. It is evident that several of the same OASIS-C data items are creating questions for many of the providers. And it is interesting to note that in one of the recent "Home Health Line" (HHL) publications, the results of a HHL "OASIS-C Follow-Up Survey" indicated that the top 5 OASIS-C data items that agencies all over the country are struggling with are the same ones the Missouri providers are also struggling with.

Some of the questions I have received from providers have already been answered by CMS and published in the CMS Quarterly Q&As (October 2009 and January 2010). There are some that I have not found published yet but I have received guidance on how to answer them via e-mail. I anticipate more guidance on some of these issues will be published in the April 2010 Q&As.

I have compiled the most frequent questions from providers on some of the OASIS-C data set items and have attached the CMS responses to this Bureau Talk. I have noted whether the Q&A is already published or whether I have just received an e-mail response from CMS. Some of the issues resolve around "what will the surveyor be looking for?" and I have noted if the response is based on the surveyor's perspective in relation to state or federal regulation.

Please see ATTACHMENT B for these Q&As.

OASIS AUTOMATION-CONVERSION TO PERSONAL LOGIN ID's

CMS is changing the way Home Health Agencies login to the OASIS Submission System and CASPER Reports.

A conversion will take place to move from state-assigned shared agency login IDs to personal login IDs. Agency users will be required to register for personal login IDs, and will no longer be able to use the shared agency ID to login to the OASIS Submissions Systems and Casper Reports.

This conversion for Missouri will begin on Tuesday, June 1, 2010. Your agency will be allowed two personal login id's. Your designated staff will not be able to complete the registration process until June 1, 2010.

If you have any questions, please contact Debi Siebert, OASIS Automation Coordinator, at 573/751-6332. Please refer to the OASIS Individual ID Registration User's Guide for further instructions.

Please see ATTACHMENT C for this guide.